Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 2/2/12
Amount 163500

62442

I. IDENTIFICATION

Name SAYRE CHRISTIAN VILLAGE NURSING HOME, INC.

Address 3840 CAMELOT DRIVE

City/County/Zip LEXINGTON, FAYETTE, KY 40517

Telephone number 859-271-9000 APHILLIPS@SAYRE.US

Administrator ANN PHILLIPS

Date facility operation began at current address 1984

Date facility began operation under current owner SAME

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	109	109
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State
County
City
(Private)

Profit
(Nonprofit)

Individual
Partnership
(Corporation)

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

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FEB 02 2012
OFFICE OF INSPECTOR GENERAL

(OVER)

If facility owned or leased by a corporation, complete the following:

Name of corporation SAYRE CHRISTIAN VILLAGE NURSING HOME, INC

Address of corporation 3840 CAMELOT DRIVE, LEXINGTON, KY 40517

President or Chairman GUY COLSON

Vice President RON FEY

Secretary JERRY HERNDON

Treasurer J. L. LYNN

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Ann Phillips, Administrator — ADMINISTRATOR — 1/27/12

Signature of authorized representative — Title — Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)